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field of general paralysis. To the question whether the two cases might not be considered as an acute infectious brain disease, the author thought that this was disproved by the long prodromal stage in one case and the failure of all evidences of infection at the examination of the internal organs. Also up to this time, as Fr. Schultze has pointed out, no fibre atrophy has been found in the brain in acute infectious diseases.

ROCQUES, *De l'alcoolisme et de la paralysie générale*, Thèse de Paris, 1891 No. 230.

For a number of years general paralysis and alcoholism have shown a progressively ascending scale in Paris. The curves of the two diseases show a parallel course. Authors are divided upon this question. Some (Foville, Garnier) think that alcoholism is the cause of this increase of general paralysis, while others (Lasègue, Bail, Christian and Ritti) on the contrary think that alcoholism is only an accompanying factor, a symptom of the initial period of general paralysis, during which the patient under a general excitement gives way to excess of drink. Rocques holds to this last opinion. When the alcohol is eliminated and the alcoholic delirium has disappeared, the general paralysis alone comes to observation and continues its slowly progressive course. There are a great many patients classed as alcoholics who should be classed as paralytics. This error in statistics shows the proportion of paralytics to be 20% of insane patients instead of 27% as it should be, and is the cause of a corresponding increase in the proportion of alcoholics. It is necessary to reserve a diagnosis at the outset, since the prognosis of alcoholism is often favorable, while that of general paralysis is fatal. The responsibility of the alcoholic is a subject of discussion, while that of the paralytic is fixed.

Although alcoholism and general paralysis increase with parallel steps in urban districts, such as the department of the Seine and that of the Rhone, and although they are both rare in agricultural regions such as Lozère, yet in certain alcoholic countries there is proof of the rarity of general paralysis. This is the case in Finisterre, one of the departments where alcoholism plays the greatest ravages, yet where general paralysis forms only 0.62% of the cases of mental disease. The same facts are observed in countries that are manifestly alcoholic, such as Ireland, Scotland, Sweden and Norway, and Canada. Alcoholism may lead at length to general paralysis, alcoholics may beget children predisposed later to general paralysis. When general paralysis develops in an alcoholic, it assumes a special form, pseudo-general paralysis (Westphal), which is distinguished by numerous characteristics and especially by the course of the disease. It may be cured, or it may relapse. True general paralysis recovers very exceptionally; remissions are observed, after which it continues. Pseudo-general paralysis may begin again.

REGIS, *Note sur le diagnostic différentiel de la lypémanie hypocondriaque et de la paralysie générale progressive*, Gazette médicale de Paris, 1890 (7) VII. 1, 13.

Regis cites four cases in which there was difficulty in diagnosing between hypochondriacal melancholia and general paralysis. In his conclusions he gives the diagnostic points of different authors and then his own. The principal distinctive characteristics given by different authors are: 1. The hypochondriacal delusion of general paralysis has a particular stamp of absurdity, hebetude and incoherence. It appears suddenly, it is changeable and inconsistent. The patients do not argue and they speak without conviction, and they show but little zeal in complaining of their ills (Baillarger, Marcé, Voisin, Luys, etc.).

The delusion of melancholia may be monotonous, but it does not present the same character of absurdity. The patient sees his disease, the reason, and the explanation, endeavors to convince, makes complaints, becomes angry with his contradictors.

2. In general paralysis the hypochondriacal delusion may be complicated at any moment with delusions of an ambitious nature. This is never the case in melancholia.

3. The hypochondriacal delusion of general paralysis is not favorably influenced by morphine, contrary to the case in melancholia (Voisin).

4. In general paralysis the subjects are not hereditarily predisposed. There have been no previous nervous disturbances (Mendel).

5. General paralysis, and consequently the hypochondriacal delusion accompanying it, come on between 35 and 45 years of age (Mendel, Mickle).

6. The examination of the organs is almost always negative in general paralysis (hypochondria *sine materia*), (Mendel).

7. In general paralysis there sometimes comes on from the beginning slight apoplectiform or epileptiform attacks, pupillary and spinal symptoms (Mickle).

8. Subsequently, the signs of dementia paralytica can be established.

9. In anxious melancholia the hypochondriacal delusion is accompanied by ideas of damnation and of possession, by analgesia, by a tendency to suicide, and to voluntary mutilations, and by the fear of not being able to die. The delusion of negation and of enormity develops, and of the doubling of the personality (Cotard, Séglas).

These distinctive characteristics are far from being sufficient in practice to give certainty. And it is among the most important cases, those dependent on the nature of the delusion and on heredity, that they have the least value, since they may be found in both forms of the disease. Regis adds the following as being of some possible service:

1. Melancholia with hypochondriacal delusion is observed especially at an advanced age from 45 to 60 years. It is encountered more frequently among women than among men, in the proportion of eight cases to twelve, contrary to what is found in general paralysis. It is, like every psychosis, more rare among syphilitics than general paralysis, since the existence of a previous syphilis constitutes a presumption in favor of general paralysis.

2. The hypochondriacal delusion of melancholia does not appear at the beginning of the attack, but a longer or shorter time afterwards, some months or some years. It is constantly consecutive to the ordinary delusion of melancholia, especially to the delusion of imaginary culpability, which is the type. It continues associated to the delusion, and joins itself logically with it. It is tenacious, fixed and persistent. It is rarely accompanied by hallucinations; while on the contrary the terrifying dreams, the fear of death, the refusal of food, the tendency to suicide are almost the rule.

The patient is subject to paroxysmal crises more or less acute. During many years the intellect remains intact, the memory precise; the lucidity more or less great, sometimes complete.

3. The examination of the viscera is habitually negative; there is stomachic and intestinal inertia, constipation, frequency of the pulse, palpitations and more rarely other functional troubles. Emaciation is rapid; a true cachexia sometimes supervenes.

4. Recovery is possible; nevertheless patients may end in suicide, marasmus or the chronic state. It is especially in these last cases that one observes Cotard's delusion of negation, which appears to be the terminal stage of this form of melancholia.

In conclusion, Regis says that the hypochondriacal delusion as a special characteristic of general paralysis may be encountered in the

same form in anxious melancholia; that the diagnosis in these cases may present real difficulties; that, to solve the problem, it is necessary to bear in mind all the clinical elements of distinction.

ROUSSET, *Du rôle de l'alcoolisme dans l'étiologie de la paralysie générale*, Bull. med. de Paris 1891 V. 743; Gaz. d. hôp. Paris 1891 XIV. 871. (Abstract in Centralbl. f. Nervenheilk. 1891 Oct.).

At the session of the Congress of French alienists at Lyons in August, 1891, Rousset gives an extended review of this subject and makes clear the present position of the question. After showing the difficulties of the investigation of mental diseases because of the uncertainties of the clinical data, he reviews the different historical phases of the relations between progressive paralysis and alcoholism, showing the differences in definition that have been held on this subject among clinicians.

In the second place he treats of the errors which have often occurred, since the alcoholic excesses, which are very frequent in the beginning of general paralysis, were often taken for the cause of the disease. Twenty-two personal observations illustrate the different clinical varieties of alcoholic general paralysis. The conclusions of the author are as follows:

1. The rôle of alcoholism in the etiology of progressive paralysis has at all times been the subject of numerous controversies. The views of the authors may be classed in four principal divisions.

2. Certain patients considered as alcoholic paralytics began in fact in alcoholic excesses, but after the beginning of the general paralysis, so that these excesses are to be considered as results not as causes of the disease. This condition of recently acquired alcoholism need not therefore be taken into account in the causation of the meningo-encephalitis.

3. The correlative advances of alcoholism and general paralysis ought not to mislead us to the conclusion that one of these diseases has been produced by the other. The geographical and ethnographical relations do not seem to speak for the importance of alcoholism in the causation of progressive paralysis.

4. Extracts from the reports of all the asylum directors of France clearly show that the views of clinicians on this subject are still very much divided.

5. It appears that alcoholism plays a smaller rôle in the etiology of general paralysis than that uncertain, often unknown and impalpable "something" that is found in all diseases, and which seems to be a necessary condition for the development of the meningo-encephalitis, namely predisposition, which, according to the individual, may be cerebral, rheumatic and nervous, or alcoholic. In some, not very frequent cases, chronic alcoholism may bring on general paralysis without this predisposition, since it brings on a process of connective tissue growth and brain sclerosis.

Magnan of Paris opened the discussion by a clinical and anatomical demonstration of chronic cerebral alcoholism and insisted on the importance not only of the individual but also of the organs for the localization of the alcoholic lesions. For him there exists a general paralysis, but not an alcoholic general paralysis. The patients designated by this last name may be divided into three groups: first, chronic alcoholics with cerebral lesions; second, true general paralytics, who have remissions in the first stages of the disease; and third, the hereditarily degenerated, who under the influence of alcohol show cerebral symptoms which simulate progressive paralysis.

Régis of Bordeaux, from his observations in Castel d'Andorte, thought that it must be assumed that alcohol played only a secondary rôle in the etiology of general paralysis in the upper and middle classes of the